# Auto Accident Checklist

- ✓ **WHEN AN ACCIDENT OCCURS:** If injured, seek medical attention immediately. Employees and volunteers are expected to use the County's designated physician(s) or hospital(s) whenever possible. See checklist on Industrial Injuries for detailed instructions.

- ✓ **FORMS**: When an auto accident or liability incident occurs, employees are instructed to report to their supervisor and complete the NOTICE OF LOSS/ACCIDENT FORM. This form should be forwarded to the Risk Management Division **within 2 business days** from the date of the incident. A copy of all party's insurance cards should be included with the packet with submitted to Risk Management.

- ✓ **PHOTOGRAPHS**: Photographs of vehicle damages shall be forwarded to the Risk Management Division, to be included with the report.

- ✓ **CONTACT THE POLICE**: A Police Report should be filed for all **moving violations and incidents involving an additional party.**

- ✓ **DRUG AND ALCOHOL TESTING**: Post-Accident Testing must be performed in accordance with **Douglas County Policy 100.14, Section F**. All drivers must contact their supervisor for instructions before leaving the scene of the accident.

- ✓ **VEHICLE REPAIRS**: Damaged vehicles must be inspected by Fleet within 3 business days of the incident, regardless of the level of damage. Following the initial inspection, Fleet will schedule a time for estimates and repairs to be completed. Departments are expected to work with Fleet to have repairs completed in a timely manner. All Douglas County vehicles shall be maintained in good working condition.

**AUTO INSURANCE:** TRAVELERS INDEMNITY CO.
201 CONCOURSE BLVD. SUITE 260
GLEN ALLEN, VA 23059-5643
POLICY# 8102S964138

**DESIGNATED PHYSICIANS:**

**VALLEY**: CARSON VALLEY HEALTH
897 IRONWOOD DR.
MINDEN, NV 89423
(775) 782-1615

**LAKE:** BARTON MEMORIAL HOSPITAL
2170 SOUTH AVE.
SOUTH LAKE TAHOE, CA
(530) 542-3000

**QUESTIONS**: Please contact Human Resources/Risk Management at (775) 782-9860

# NOTICE OF ACCIDENT/LOSS FORM

* Attach Sheriff's report and forward to Douglas County Risk Management **WITHIN 48 HOURS** *

| INCIDENT DATE: | TYPE OF LOSS | (1) Motor Vehicle ☐ | (2) Property ☐ | (3) Liability ☐ |
|---|---|---|---|---|

## (1) MOTOR VEHICLE ACCIDENT (Vehicle #1 - County Vehicle)

| Year, Make, Model | License Number | County Vehicle ID Number | VIN(Vehicle Identification Number) |
|---|---|---|---|
| Driver's Name | | Position Title | Department |
| Time of Day that Accident Occurred | | Residence Phone | Work Phone |
| Location of Accident (Note highway/street name, intersection, etc) | | Contact Person | Phone |
| Describe Damage to Vehicle (complete page 2 & 3) | | | |

## (2) PROPERTY DAMAGE (or Vehicle #2)

| Year, Make, Model | License Number | VIN(Vehicle Identification Number) | | |
|---|---|---|---|---|
| Owner's Name | | Residence Phone | | Work Phone |
| Owner's Street/Mailing Address | | City | State | Zip |
| Driver's Name (Leave blank if same as owner ) | | Residence Phone | | Work Phone |
| Driver's Street/Mailing Address | | City | State | Zip |
| Describe Damage (complete page 2 & 3) | | | | |

## (3) LIABILITY/INJURY

| (1) Name | Residence Phone | | | Describe Injury (attach additional info) |
|---|---|---|---|---|
| Street/Mailing Address | City | State | Zip | |
| (2) Name | Residence Phone | | | Describe Injury (attach additional info) |
| Street/Mailing Address | City | State | Zip | |

## WITNESSES or PASSENGERS

| (1) Name | Residence Phone | | | Work Phone |
|---|---|---|---|---|
| Street/Mailing Address | City | State | Zip | |
| (2) Name | Residence Phone | | | Work Phone |
| Street/Mailing Address | City | State | Zip | |
| (3) Name | Residence Phone | | | Work Phone |
| Street/Mailing Address | City | State | Zip | |

## SHERIFF

| Sheriff Investigation? (circle one) Yes No | Highway Patrol Investigation? (circle one) Yes No |
|---|---|
| Investigating Officer | Investigating Officer |
| Report Number | Report Number |

## RISK MANAGEMENT ONLY

| File Name: | Date Received: |
|---|---|
| Insurance Claim Number: | Date Sent to W/C: |
| Risk Management Signature: | Copies sent to: |

j:\Safety\Forms\Accident Form

**DOUGLAS COUNTY**
**NOTICE OF LOSS/ACCIDENT**
Continued
(Please print or type)

DOUGLAS COUNTY

**Describe how the accident happened:**

Weather: ______________________________

Road Conditions: ______________________________

Your Speed: ______________________________

**Description of the accident and sequence of events leading to the accident:**

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

**Diagram:** **Fill in name of streets, locate vehicles, indicate direction of travel:**

**Person Submitting Report:**

Name: ______________________ Title: ______________________

Department: ______________________ Phone: ______________________

Date: ______________________

Please print or type clearly.
Attach all completed forms/photos/invoices.
Forward to Risk Management within 48 hours.

## VEHICLE COLLISION REVIEW

**To be completed by Supervisor**

(please print or type)

Name of Employee: ______________________ Date of Accident: ____________

Type of Collision: Vehicle Ahead ☐ Vehicle Behind ☐ Backing ☐ Animal ☐ Side Swipe ☐
Bicycle ☐ Pedestrian ☐ With Fixed Object ☐ Run-off Road ☐ Head On ☐
Other: ______________________

Did our driver violate a traffic regulation? Yes ☐ No ☐

Was our driver given a citation by police? Yes ☐ No ☐

In your opinion, what caused the collision? ______________________

______________________

Did our driver claim that any malfunctioning or defective vehicle component(s) caused the collision?
Yes ☐ No ☐

Were any of the following conditions less than good at the time of the collision?
Traffic ☐ Weather ☐ Light ☐ Road ☐
Other: ______________________

What was the condition of the driver? Normal ☐ Fatigued ☐ Sick ☐ Intoxicated ☐

Was the driver tested for drug & alcohol? Yes ☐ No ☐ Location of testing?____________

Other: ______________________

______________________

Was the collision preventable? Yes ☐ No ☐
(Preventable defined as: an accident in which the driver in questions failed to do everything he/she reasonably could have done to prevent the occurrence.)

If preventable, what corrective action do you recommend to prevent a future occurrence of the same type?

______________________

______________________

______________________

______________________

______________________

Was disciplinary action taken against the driver? Yes ☐ No ☐

Print name of supervisor: ______________ Division: ______________

Signature of supervisor: ______________ Date: ______________

Please print or type clearly.
Attach all completed forms/photos/invoices.
Forward to Risk Management within 48 hours.

# Accident Witness Statement



Date of Incident: ______________________________ Time of Incident: ______________________

Injured Person's Name: ____________________________________________________________

Name of Witness: _________________________________________________________________

Home Address: ___________________________________________________________________

City: _______________________ State: ________ Zip: __________ Phone:________________

Mailing Address: ___________________________ ________________

Location of Accident (address): ______________________________________________________

Area (loading dock, bathroom): ______________________________________________________

Describe fully how the accident occurred (including events that occurred immediately before the incident):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Describe bodily injury sustained (be specific about body parts(s) affected): ________________________

________________________________________________________________________________

________________________________________________________________________________

List any additional witnesses present at the time of the accident: ____________________________

________________________________________________________________________________

________________________________________________________________________________

Signature of Witness: __________________________________ Date: ______________________